TALLAHASSEE DIAGNOSTIC IMAGING
MRI SCREENING FORM

PATIENT NAME: _____ **DATE:** _____

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following.

☐ Yes	☐ No	Cardiac pacemaker or internal pacing wires
☐ Yes	☐ No	Implanted cardiac defibrillator or internal pacing wires
☐ Yes	☐ No	Aneurysm clip(s) or coils
☐ Yes	☐ No	Neuro-stimulator
☐ Yes	☐ No	Implanted drug infusion device (insulin or infusion pump)
☐ Yes	☐ No	Bone growth/fusion stimulator
☐ Yes	☐ No	Cochlear, otologic, or ear implant
☐ Yes	☐ No	Any type of prosthesis (eye, penile, etc.)
☐ Yes	☐ No	Heart valve prosthesis
☐ Yes	☐ No	Breast Tissue Expander(s)
☐ Yes	☐ No	Electrodes (on body, head, or brain)
☐ Yes	☐ No	Intravascular stents, filters, or coils
☐ Yes	☐ No	Shunt (spinal or intra-ventricular)
☐ Yes	☐ No	Vascular access port (Infusaport)
☐ Yes	☐ No	Any implant held in place by a magnet
☐ Yes	☐ No	Transdermal delivery system (Nitro or pain medicine patch)
☐ Yes	☐ No	Retinal Buckle for Retinal Detachment
☐ Yes	☐ No	Body piercing(s)
☐ Yes	☐ No	Any metal fragments (shrapnel, bullet, foreign body, etc.)
☐ Yes	☐ No	Aortic clip
☐ Yes	☐ No	Wire sutures or surgical staples
☐ Yes	☐ No	Harrington rods (spine) for Scoliosis Correction Surgery
☐ Yes	☐ No	Metal rods in bones
☐ Yes	☐ No	Joint replacement _____
☐ Yes	☐ No	Bone/joint pin, screw, nail, wire, plate
☐ Yes	☐ No	Hearing aid ***(Remove before MRI)***
☐ Yes	☐ No	Dentures ***(Remove before MRI)***
☐ Yes	☐ No	Claustrophobia
☐ Yes	☐ No	Anxiety

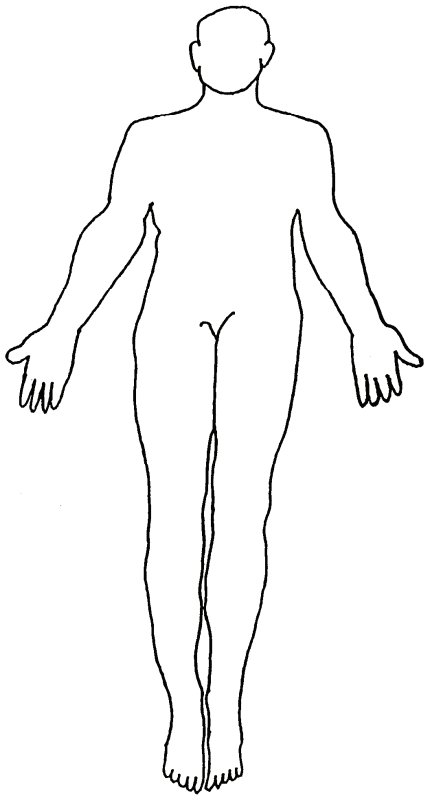
Reviewed by: **TDI Staff**

Front Desk Staff Initials: _____

Medical Assistant Initials:_____

MR Technologist Initials:_____

Please mark on the figure below, the location of any implant, or metal inside of, or on your body.



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS DURING THE MRI EXAMINATION.
(Please continue to the other side of this form.)

Tallahassee Diagnostic Imaging
MRI Breast Imaging History Sheet

Patient's Name: _____Last menstrual period: _____

MRI BREAST IMAGING							
Please check answer	**YES**	**NO**		**YES**	**NO**	**RT**	**LT**
Any chance you might be pregnant?			Do you or your health care provider note a specific lump in your breast that is **new or has changed***? How big?* _____				
Have you nursed a baby in the last 6 months?			Constant specific area of pain?				
Are you on hormone replacement therapy?			Spontaneous discharge from nipple? *What color?*				
Have you had breast cancer? *When?*_____ RT __ LT __			Previous breast surgery? *Circle* *Date* Mastectomy _____ Lumpectomy _____ Mammotome _____ Ultrasound Guided _____ Implants _____ Cosmetic reduction or lift _____				
Family history of breast cancer? *Check:* *Age at diagnosis* Mother ____ _____ Sister(s) ____ _____ Daughter(s) ____ _____							
Previous radiation therapy?			Previous chemotherapy?				
Prior mammogram? *Where?* _____ *When?* _____			History of trauma to the breasts, chest or chest wall? *When?*_____				
Any other cancer? *What kind?*_____							

Patient Signature: _____ **Date:** _____

For All Patients:

1. **Do you have any drug allergies?** . . . . . ☐ No ☐ Yes

   If "Yes", please list: _____

2. **Have you ever had a reaction to contrast material (dye) for ANY medical test?** . . . . . ☐ No ☐ Yes

   If "Yes", what test did you have? _____

   Describe the reaction: _____

   _____

3. ***Please circle any of the conditions you have or have ever had:***

Kidney disease	Diabetes	Multiple myeloma	Lupus
Kidney transplant	Dialysis	Sickle cell anemia	Cancer/tumor
Kidney failure	Stroke	Heart failure	High blood pressure
One kidney	Asthma	Tuberculosis	

4. Have you ever worked with metal (grinding, fabrication, etc.) or have you ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings or metallic foreign body)? . . . . . ☐ No ☐ Yes

5. If you answered "Yes", was the metallic object removed by a physician? . . . . . ☐ No ☐ Yes

6. If you answered "Yes", were you told by the physician that he/she removed all of the metal? . . . . . ☐ No ☐ Yes

For Female Patients:

1. Are you or could you be pregnant or experiencing a late menstrual period? . . . . . ☐ No ☐ Yes

   Date of last menstrual period: _____/_____/_____

2. Are you breastfeeding? . . . . . ☐ No ☐ Yes

_____ Date: _____/_____/_____

Signature of Person Completing Form

Form completed by: ☐ Patient ☐ Other: _____

_____ Date: _____/_____/_____

TDI Employee Reviewing MRI Safety Form